Prior Authorization Request Form for
tezepelumab-ekko (Tezspire)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 12 months. Renewal PA criteria will be approved indefinitely.
For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Tezspire.*	☐ Yes Proceed to question **2**	☐ No Skip to question **3**
2. Has the patient had a positive response to therapy with a decrease in asthma exacerbations, improvements in forced expiratory volume in one second (FEV1) or decrease in oral corticosteroid use?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 12 year(s) of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by an allergist, immunologist, or pulmonologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a diagnosis of severe persistent asthma?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the provider acknowledge the FDA warnings and precautions associated with Tezspire?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the patient's asthma uncontrolled, despite adherence to optimized medication therapy regimen, defined as requiring hospitalization for asthma in past year?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**
8. Is the patient's asthma uncontrolled, despite adherence to optimized medication therapy regimen, defined as requiring two courses of corticosteroids for asthma exacerbation in past year?	☐ Yes Proceed to question **10**	☐ No Proceed to question **9**
9. Is the patient's asthma uncontrolled, despite adherence to optimized medication therapy regimen, defined as requiring daily high-dose inhaled corticosteroids with inability to taper off the inhaled corticosteroids?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and failed an adequate course (3 months) of TWO of the following while using a high-dose inhaled corticosteroid: long-acting beta agonist (LABA, for example, Serevent, Striverdi), OR long acting muscarinic antagonist (LAMA, for example, Spiriva, Incruse), OR leukotriene receptor antagonist (for example, Singulair, Accolate, Zyflo)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[26 April 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: